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Contracted Health Care Worker Examination and Immunization Verification Form

Infectious Disease	Dates (DD-MM-YYYY)	Proof of Immunity
Varicella (chickenpox)*	1. __-__-____ 2. __-__-____	Physician documented varicella (attach) OR Positive IgG titer: __-__-____ (titer date)
Measles*	1. __-__-____ 2. __-__-____	Positive IgG titer date __-__-____
Mumps*	1. __-__-____ 2. __-__-____	Positive IgG titer date __-__-____
Rubella*	1. __-__-____ 2. __-__-____	Positive IgG titer date __-__-____
Tetanus (T, Td, Tdap)*	__-__-____	
Diphtheria (Td, Tdap)*	__-__-____	
Pertussis (Tdap)*	__-__-____	
Influenza (seasonal) (all HCWs)	__-__-____	
Tuberculosis (all HCWs with negative history of TB or exposure)	1. __-__-____ 2. __-__-____ (2-52 weeks apart) Result (circle one): Negative Positive	Blood assay for M. tuberculosis date __-__-____ Result (circle one): Negative Positive
Tuberculosis (all HCWs with positive history of TB or exposure)	Latent TB infection prophylaxis? Year ____ started or complete (circle one)	CXR date __-__-____ Result (circle one): Negative Positive
Hepatitis B (only applies to HCWs with potential occupational exposure to bloodborne pathogens)	1. __-__-____ 2. __-__-____ 3. __-__-____ If necessary (i.e., if first titer negative): 4. __-__-____ 5. __-__-____ 6. __-__-____	IgG (HBsAb) titer date __-__-____ Result (circle one): Negative Positive IgG (HBsAb) second titer date __-__-____ Result (circle one): Negative Positive Counseling provided date (if repeat titer negative) __-__-____
Other (identify)	__-__-____	
Latex sensitivity screening	__-__-____	History IS / IS NOT (circle one) consistent with latex sensitivity

* Applies only to HCWs with direct patient contact.

I certify that _____ (*name of health care worker*) was examined on __-__-____ (*mm dd yyyy*) and WAS / WAS NOT (*circle one*) found to be in good health, meeting the immunization and screening required above, and free of any medical condition or infectious disease that may prevent his/her ability to perform services as a Health Care Worker.

Provider's Signature: _____ Provider's Name: _____

Phone Number: _____ Date: _____

This section for Navy use only

Completed form and accompanying documentation reviewed and found complete.

Reviewer's signature _____ Name (print) _____ Date _____